FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Return to:
FLEXBEN CORPORATION
P.O. Box 991
Mequon, WI 53092-0991
(800) 582-9740 ♦ (262) 238-4000
Fax: (262)238-4026
www.flexbenwi.com

Please Do Not Staple Your Receipts to this Page.

Section 1 This section must be completed fully for all claims.

Please Print

Employer Name:_____

Employee Name:_____ Employee ID: | | | | | | | | | |

Address:_____ Email Address:_____

City: _____State:_____ZIP: | | | | | | Daytime Phone Number:(_____)_____-_____

☐ Check here if new address

Section 2 This section must be completed for all claims incurred by you, your spouse, or other eligible dependents. Supporting documentation must be attached.

Benefit Type Codes	
10 Day Care	24 Misc Medical
20 Medical	
21 Pharmacy	
22 Vision	
23 Dental	

Example

Ex. 20 Health Care Expenses 07-22-2002 08-04-2002 $ 6,53.29

Please use another form for claims in excess of 5 line items.

EXPENSES: We accept itemized claims only.

Item	Benefit Type	Description	Service Dates (MM-DD-YYYY)			Amount Requested
1.					20 / 20	$, .
2.					20 / 20	$, .
3.					20 / 20	$, .
4.					20 / 20	$, .
5.					20 / 20	$, .

Total Amount Requested: $, .

Day Care/Dependent Care Provider and Dependent Information:

_____ Age _____ Age _____ Age
Dependent's Name Dependent's Name Dependent's Name

If bills or receipts are not available, your service provider must complete the following:

_____ _____
Provider's Signature & Tax ID Date

Section 3 Employee's Signature is required to process this claim.

I request payment from the reimbursement account for the expenses itemized above. I certify that I have not (and will not) request reimbursement under this plan or from any other source for these expenses. I further understand that reimbursed expenses cannot be claimed as a credit on my personal income tax return.

Employee Signature:_____ Date:_____

We want to promptly process your claim. Please complete all appropriate sections as the claim form will be returned to you if incomplete. Please keep a copy of this claim for your records.

PLEASE SEE REVERSE SIDE

Place Non-Compliance Sticker Here

HOW TO FILE YOUR CLAIM

Section 1

Complete ALL personal information on the reverse side of this form.

Indicate the totals of the healthcare and/or daycare claims being submitted. These accounts reimburse you for services incurred during the plan year. If you are submitting expenses for more than one plan year, please complete a new form for each plan year. The date(s) of service determines claim eligibility, not the date you pay or receive billing for the service.

Section 2

BENEFIT TYPE CODES
Please refer to the example in Section 2 on the front of this page and select the proper two digit benefit type code for the expense you are claiming in each line item. This will allow for faster and more accurate processing of your claim.

HEALTH CARE EXPENSES--Incurred by you, your spouse, or other eligible dependents.
Attach to this claim form one of the following:

- The insurance explanation of benefits (EOB) statement returned to you from the insurance carrier indicating the amount for which you are responsible. Remember any medical, dental, or vision expense covered by insurance in part or in full must first be submitted to your insurance carrier.
- When there is no insurance for healthcare expenses, submit an itemized bill with the following information:
    - Name of provider and patient
    - Service cost, date, and description
    - Notation when there is no insurance coverage
- Co-pay receipts if you are covered under a managed care or a prescription drug plan.
- Orthodontic expenses are reimbursed over the period of time the appliances are worn as described in the treatment plan your orthodontist provided to you. Send a copy of this treatment plan to our office, along with your first claim documenting the expected length, cost of service, and insurance coverage. For subsequent monthly claims, simply indicate on the claim form the amount and month you are claiming (based on treatment schedule.)

Total your expenses and enter the amount on the front of this form. **Canceled checks, balance due statements, or undocumented receipts are not acceptable documentation per IRS regulations.**

DAY CARE/DEPENDENT CARE EXPENSES
Complete this section if you have incurred expenses for the care of a dependent to allow you and/or your spouse to work. This form substantiates expenses you have incurred with the provider listed on this form. Indicate the name(s) and age(s) of person(s) who have received day care/dependent care. Copies of bills and receipts must be attached to support your request for reimbursement. Canceled checks are not acceptable documentation. If those documents are not available, you must have the provider of service sign the appropriate space and indicate tax ID number on the front of this form.

Section 3

SIGN the claim form. This is required on all submissions, otherwise the claim will not be processed.

This Flexible Spending Account is regulated by the Internal Revenue Service. Our documentation guidelines are intended as a means to qualify your expenses for approval and reimbursement. It is the responsibility of each participant to comply with these guidelines and to avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements will delay the payment of your claim.

As a reminder, your election is irrevocable during the plan year. If allowed by your plan provisions, an election can only be changed during the plan year if you have a qualifying status change. The request has to be made timely and the requested election change has to be in line and consistent with the event.

This outline is intended for quick reference. For more specific guidelines, please call FlexBen Corporation at: **Milwaukee area local call: 1-262-238-4000 (all 11 digits must be dialed) or outside metro Milwaukee: 1-800-582-9740.**

FlexBen has a toll free Automated Account Inquiry Line that you can call 24 hours a day to verify information about your account. This telephone number is **1-800-988-9094**. When calling this number, you will be required to enter your employee ID number and the 4 digit PIN (personal identification number) sent to you in your confirmation letter.

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